LEHIGH VALLEY HOSPITAL

Medical Staff Progress Notes

MAY

1997
Volume 9
Number 5

In This Issue . . .

From the President . . .

> ***One never notices what has been done;***
> ***One can only see what remains to be done.***
>
> **- Mdme. Marie Curie**

Well .... I'm almost one quarter through my tenure as President. It seems the honeymoon period is finally over.

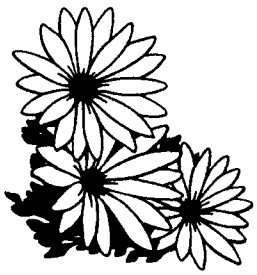
Troika has begun to involve itself in issues effecting the Medical Staff and to evolve the proceedings of the Medical Executive Committee. I've reported our successes to you in previous issues of ***Medical Staff Progress Notes***. Most recently, we've helped to broker some difficulties encountered with the incorporation of Respiratory Therapy into the Patient Centered Care model. While some work still remains, I think it's fair to say that some new optimism exists with regard to this issue on the part of therapists, nurses, physicians, and administration, alike.

The single largest challenge to Troika is representing, unifying (where possible), and protecting this Medical Staff. I believe we are practicing in an era of unprecedented external pressures which continue to make our professional lives more difficult. For those of you who needed a little extra light reading, I'm enclosing a recent article which highlights potential conflicts which might result from new changes in the Medicare System.

Some of the most immediate problems are right here at Lehigh Valley Hospital, however. Because of this, the Medical Executive Committee will discuss Alex Rae-Grant's committee work on Citizenship and Loyalty. The hope is that we can bring suggestions to the Board on what the staff feels would be a reasonable expectations and rewards system. I have to confess, I see no other issue which will consume a larger proportion of our time over the next 18 months.

Here's to the work still to be done!

Robert X. Murphy, Jr., MD
President, Medical Staff



Legislative Update

Thanks again to those of you who attended the first quarterly meeting of the Medical Staff and extended such a fine welcome to Dr. Greco, President of the Pennsylvania Medical Society (PMS).

As you can see from the attached letter, Dr. Greco was impressed by the audience's interest and concern. Dr. Greco is appealing to any member of our Medical Staff, who is not currently a member of the Pennsylvania Medical Society, to consider joining the Society. Increased membership can only strengthen our position as we continue to fight for Tort and CAT Fund reform, as well as other medical issues. I feel it's important to stress that the PMS has officially deunified from the AMA. No longer are members of the PMS required to be members of the AMA.

Please support your State society. If you are interested, contact either Lou Eister, Executive Director, Lehigh County Medical Society, at 437-2288; Judd Mellinger-Blouch, Director of Marketing for the State Society, at 1-800-228-7823, or myself in the Medical Staff Office at 402-8980. Remember, it is only by virtue of a strong, unified society that we will have the strength to be heard in Harrisburg!

Robert X. Murphy, Jr., MD
Chairman, Legislative Committee
Lehigh County Medical Society
and
OMSS Representative
Lehigh Valley Hospital

Some concern has been raised regarding the availability of medical consults in urgent situations at 17th & Chew. Please be assured that urgent medical consultations are available at 17th & Chew, 24 hours a day. Also, the LVPG-Medicine group has an attending physician or resident back-up covering the house at all times.

If an urgent medical consultation is required of the LVPG-Medicine group, please call 402-1150.

Tuberculosis Revisited

Tuberculosis continues to be a threat in our community. Therefore, we must prevent a communicable patient from entering the hospital environ-ment without proper precautions. Early identification of patients potentially infected with TB is imperative to a well designed TB program.

A TB self-screening tool was implemented in the outpatient clinics and the Emergency Department in July, 1996, to identify individuals who may be at risk for TB. For private patients, we are enlisting the support of the **ADMITTING PHYSICIAN** to communicate with the admitting areas that the patient is a R/O TB so that proper isolation precautions can be promptly initiated. The same consideration should be made for private patients directed to outpatient testing areas for x-rays, blood work, etc., if R/O TB contributes to the differential diagnosis. In these cases, sending the patient to the hospital with a mask would be appropriate.

The Infection Control Department recognizes and appreciates all efforts made to comply with these measures intended to reduce the risk of Tuberculosis transmission to the patients staff and visitors in the Lehigh Valley Hospital and Health Network.

Tamoxifen and Cataract Formation

by David Prager, MD, Principal Investigator, NSABP

Tamoxifen is a drug that is frequently used for the treatment of breast cancer in both the adjuvant and metastatic setting. Because so many patients are taking Tamoxifen, you may be asked by some of your patients what they should do concerning the recently observed "slight" risk of developing Tamoxifen associated cataracts.

The following is a summary of recommendations from the National Surgical Adjuvant Breast Project (NSABP):

- Although baseline eye examinations are not being required, it is valuable to determine the baseline level of eye pathology prior to starting Tamoxifen, partly to avoid associating visual changes with Tamoxifen when pre-existing conditions are present.

- In the asymptomatic patient, regular eye exams at least every two years are sufficient. These exams should include careful evaluation of the lens and biomicroscopic evaluation of the retina. There are no specific diagnostic tests for monitoring early Tamoxifen-related visual changes, other than visual acuities.

- In the presence of confounding eye pathology or other vision concerns, the frequency of exams should be increased accordingly by the patient's eye care provider.

- The presence of a few intraretinal crystals (i.e., less than 10) in the absence of macular edema or a decrease in visual acuity does not warrant discontinuation of the drug. However, monitoring should be increased accordingly (i.e., every three to four months initially and up to every six months as per the eye care provider).

- Patients should be advised as to the increased risk of cataract development while taking Tamoxifen, but it should be noted that the magnitude of the risk is unknown. The risk is likely to be less than that observed for steroids which are widely used in medicine. Patients with cataracts should be advised that Tamoxifen may accelerate the progression of the cataract. There is no evidence to suggest that cataract surgery would be more problematic for these patients, should they develop vision impairment from these lens changes.

If you wish to receive a copy of the entire NSABP letter which was distributed to oncologists and eye care professionals, please call the Clinical Trials Office of the John and Dorothy Morgan Cancer Center at 402-0636.

The Central Document Processing boxes at Cedar Crest & I-78 have been relocated from the hallway off the main lobby to the wall outside the Medical Staff Lounge on the first floor. The move was necessary to comply with JCAHO standards.

LVHHN to Offer Vitality Plus to Persons 50+

Staying healthy and active is key to getting the most out of life, and LVHHN will soon launch an exciting new program designed to help people ages 50 and over do just that.

Called ***Vitality Plus***, the low-cost program, which debuts in early May, features many opportunities and activities for individuals and couples, from exercise classes and cooking seminars, to social galas and even dance lessons. *Vitality Plus* members also get discounts on prescriptions, health care products, travel, dining and hotel reservations, and many other products and services.

The program is available through participating family practitioners and internists in cooperation with LVHHN and other PennCARE hospitals throughout eastern Pennsylvania. According to physicians, having so many health and wellness opportunities tailored to individual patients' needs is what makes *Vitality Plus* unique.

"*Vitality Plus* is designed to help people stay healthy and have fun doing it," said Francis A. Salerno, MD, Acting Chief, Division of Geriatrics. "The heart of the program really centers on ways to extend the efforts of physicians in making a positive difference in the health of their patients."

LVHHN physicians and consumers from Lehigh, Northampton and Bucks counties played a role in developing the program. "To ensure that *Vitality Plus* will meet customer needs, we held focus groups where physicians and community members shaped the program," said John Stavros, Senior Vice President, Marketing and Public Affairs. "They gave us input on everything from the name of the program and the services included to the membership cost."

Vitality Plus is the first program of this size and scope to be offered through physician offices and their affiliated hospitals in eastern Pennsylvania. It's among the first in the nation to integrate such a diverse array of benefits into one health and wellness package.

The program's goal is to help physicians keep people well, active and productive through a comprehensive package of health education and wellness services, hospital amenities, social activities, and medical and lifestyle cost savings. For example, for a person at risk for heart disease, there are exercise programs, nutrition classes, stress reduction seminars and other resources available through *Vitality Plus*. If members have questions about insurance claims, their prescriptions or long term care, *Vitality Plus* offers qualified assistance. If an individual wants to expand social opportunities and meet people, there are special events, a dining club and travel discounts.

"*Vitality Plus* was created to appeal to different people with different needs," said Susan Hoffman, who directs the program. "But no matter what the reason is for joining, once you're a member you open the door to a wide range of opportunities and value. And it's all in one resource."

(Continued on Page 5)

(Continued from Page 4)

The cost of membership is also a key advantage of *Vitality Plus*. At $20 per year for an individual or couple, members can save up to $550 annually. For example, all new members receive two months of free exercise classes at community locations, discounts on eyewear and pharmaceuticals, long-term care insurance at below-market rates, and much more.

Vitality Plus will soon have a toll-free phone line --Vitality Link-- to keep members informed about classes, events or general health issues. People can call Vitality Link at (888) 584-PLUS to find out if their doctor is a participating *Vitality Plus* physician and receive a membership application.

Watch for advertisements about *Vitality Plus* on radio and television and in local newspapers.

***Vitality Plus* was developed by Lehigh Valley Hospital and Health Network, one of the top 40 hospitals for geriatric care in the nation, according to U.S. News and World Report.**

***Vitality Plus* members receive a comprehensive array of benefits...**

Health & Education
- **Workshops and seminars**
- **Vitality Plus newsletter**
- **Prescription review**
- **Claims and health plan counseling**

Hospital Amenities
- **Valet parking**
- **Cafeteria privileges**
- **Phone card**
- **Medical emergency card**
- **Home care visit after hospitalization**

Social Events
- **Volunteer opportunities**
- **Vitality galas**
- **Dining club**
- **Dance lessons**

Discounts
- **Long-term care insurance**
- **Eye wear**
- **Pharmacy**
- **Hearing care**
- **Travel**
- **Medical equipment**

Grand Opening for Breast Health Services

You are invited to Take Time to Celebrate Life and the Grand Opening of Breast Health Services.

On Saturday, May 3, open houses will be held at both Breast Health Services Centers from 10 a.m. to noon. Meet the Breast Health Services staff, tour the facilities, take part in educational workshops, and enjoy some light refreshments.

The Breast Health Services Centers are located at:

● 1240 S. Cedar Crest Blvd.
Suite 203
and
● 401 N. 17th Street
Suite 108

Please Note: Mammography services are now available in the Breast Health Services Centers at the above locations; they are no longer available at Lehigh Valley Diagnostic Imaging.

Outsourcing of Bactigens

Health Network Laboratories will no longer be offering bacterial antigen testing as an in-house study.

Several factors were key in making this decision:

- Multiple studies in the literature show that the sensitivity of the Bacterial antigens is approximately equivalent to that of a well-performed Gram stain.

- There is a concern for false positives using bacterial antigens. In a 1995 study done by Duke University, 1,268 clinical samples (CSF, urine, and three other fluids) were tested with a panel of bacterial antigens (*Streptococcus pneumoniae*, 3 *Neisseria meningitidis* serogroups, *Ilaemophilus influenzae*, and *E. coli* K1). Of these assays, 57 (1.1%) were positive. Of the 57 positive, 31 (54%) were false positives.

- There has been a decrease in the amount of *Haemophilus influenzae* meningitis seen because of vaccination.

- We looked at the six month period from April 30, 1996 to October 30, 1996 to evaluate our own data. 155 specimens were tested, two were positive, one of the positives was considered a false positive for *Streptococcus pneumoniae.*

In evaluating CSF for meningitis, review the other CSF screening tests, CSF protein, glucose, leukocyte count. Normal values for these tests are WBC - 0-5 cells/ul, protein 15-45 mg/ml, glucose 50-75 mg/dl. Meningitis will usually produce more than one abnormal CSF parameter including a positive smear.

If a bacterial antigen is still wanted, it may be ordered and will be sent to a reference lab. The test can be ordered in one of the following manners:

1. As a battery called "bacterial antigens" (includes all of the following individual tests)
2. As the individual tests:
   - *Hemophilus influenzae B* antigen
   - *Streptococcus pneumoniae* antigen
   - Group B Strep antigen
   - *N. meningitidis* antigen (this includes Groups A, Y, C, W 135, and B/E. coli K1)
   - *N. meningitidis group B/E. coli* K1 antigen

If you have any questions regarding this issue, please contact Georgia Colasante, Technical Specialist, at 402-5580.

Mid Atlantic Pain Specialists, operating the Center for Pain Management, is now participating with Aetna/US Healthcare.

● ● ● ● ●

Effective March 1, Affinity has been added to the Aetna/US Healthcare contract for physical, occupational, and speech therapy services. In addition, Affinity participates in the Aetna/US Healthcare Workers' Compensation Advantage Program. Primary care physicians have the option of selecting Affinity as their designated provider for all outpatient rehabilitation services.

Library News

OVID Training

To schedule a brief, hands-on OVID training session, please call Barbara Iobst in the Health Sciences Library at 402-8408.

New Additions

The following books have been purchased for the Health Sciences Library at 17th & Chew:

Medical Emergencies in the Dental Office, 4th edition
Author: Stanley Malamed
Call No. WB 105 M236m

Urogynecology and Urodynamics: Theory and Practice, 4th edition
Author: D. Ostergard, et al.
Call No. WJ 190 U78 1996.

The following books are now available in the Library at Cedar Crest & I-78:

Cecil Essentials of Medicine, 4th edition
Author: Thomas Andreoli, et al.
Call No. WB 115 C388 1997
(Reference Section)

Essential Skills in Clinical Medicine
Author: Charles Bardes
Call No. WB 39 B245e 1996

Differential Diagnosis of Infectious Diseases
Author: David Schlossberg, et al.
Call No. WC 100 S345d 1996

Textbook of Rheumatology, 5th edition
Author: William Kelley, et al.
Call No. WE 544 T355 1997 (Volumes 1 and 2 - Reference Section)

Textbook of Surgery: The Biological Basis of Modern Surgical Practice, 15th edition
Author: David Sabiston
Call No. WO 100 T3552 1997

Congratulations!

Michael W. Kaufmann, MD, Chairperson, Department of Psychiatry, was recently informed by the American Board of Psychiatry and Neurology that he passed the examination for certification of Added Qualifications in Geriatric Psychiatry.

James G. McHugh, MD, Vice Chairperson, Department of Emergency Medicine, finished 18th overall in the 5K run at the 78th Annual American College of Physicians meeting in Philadelphia on March 23. The meeting was attended by 7,000 of the most prominent doctors in the country.

Thomas D. Meade, MD, Division of Orthopedic Surgery, **Charles C. Norelli, MD**, Division of Physical Medicine/ Rehabilitation, and **Alexander D. Rae-Grant, MD**, Division of Neurology, recently set a US Masters swimming world record as three of four members of a 400 meter medley relay team. The foursome eclipsed a four year old record of 4 minutes and 21 seconds (previously held by a team from Baylor University) by two seconds in recording a new Masters world record of 4 minutes and 19 seconds. Drs. Meade and Norelli will be competing in the US Masters National Championship in May in Seattle, Wash.

Leonard A. Merlo, DMD, Division of Oral and Maxillofacial Surgery, has successfully met the requirements for board certification by the American Board of Oral and Maxillofacial Surgery in the specialty of oral and maxillofacial surgery.

Papers, Publications and Presentations

Mark D. Cipolle, MD, PhD, Associate Chief, Division of Trauma/Surgical Critical Care, co-authored a paper, "Post-trauma Thromboembolism Prophylaxis," which was published in the January issue of the ***Journal of Trauma***.

The February issue of the ***Journal of Trauma*** published the article, "Bilateral Renal Artery Thrombosis Secondary to Blunt Trauma: Case Report and Review of the Literature," which was authored by **Paul Frassinelli, MD**, Surgical Resident, **Michael D. Pasquale, MD**, Chief, Division of Trauma/Surgical Critical Care, **Craig R. Reckard, MD**, Chief, Section of Transplantation Surgery, **James J. Goodreau, MD**, Associate Chief, Division of Vascular Surgery, and **Gerald P. Sherwin, MD**, Chief, Division of General Surgery.

Robert S. Gayner, MD, Division of Nephrology, had an article published in the July, 1996 issue of ***Nephrology Dialysis Transplantation***. The article, "Delayed Function Reduces Renal Allograft Survival Independent of Acute Rejection," evaluates the relationship of delayed allograft function to acute rejection and long-term survival of cadaveric allografts.

Herbert L. Hyman, MD, Division of Gastroenterology, spoke to the Department of Family Practice at Warren Hospital on "Chronic Fatigue Syndrome and the Gut" on April 2. On April 8, he spoke to the Visiting Nurses Association in Pottstown on "Chronic Fatigue Syndrome."

A research paper, "Challenges in the Use of a Medical Outcome Scale in a Mental Health Clinic," was accepted for presentation at the annual American Psychiatric Association Convention to be held in San Diego, Calif., May 23-27.

The co-authors of the paper are **Michael W. Kaufmann, MD**, Chairperson, Department of Psychiatry, **Thomas Waser, PhD**, Director of Clinical Epidemiology, Department of Health Studies, and **Susan D. Wiley, MD**, Vice Chairperson, Department of Psychiatry.

Peter A. Keblish, MD, Chief, Division of Orthopedic Surgery, was the principal speaker at a Paris Knee Meeting, *Journees Du Genou*, on March 14 and 15. Dr. Keblish moderated sessions and presented topics on soft tissue approaches, patella controversies, and unicompartment replacement arthroplasty. The Paris Knee Meeting has become an annual event with over 200 participants from the French orthopedic societies.

Dr. Keblish also performed total knee surgery at the Hospital Bizet with demonstrations and live surgery on a patient with complex valgus knee deformity, which is his subspecialty interest within total knee arthroplasty.

Peter F. Rovito, MD, Division of General Surgery, and **Paul Frassinelli, MD**, Surgical Resident, co-authored "Laparoscopic Reversal of a Silicone-Banded Gastroplasty" which was featured in the ***Minimally Invasive Surgery Series*** of the January issue of ***Surgical Rounds***.

Thomas Wasser, PhD, Director of Clinical Epidemiology, Department of Health Studies, presented a poster, "Associations of Chronic Fatigue with Functional GI Complaints," at the East Coast Chronic Fatigue and Immune Dysfunction Syndrome Medical Conference held at Wheeling Jesuit University, Wheeling, W.Va., on April 4 and 5. The poster was authored by **Herbert L. Hyman, MD**, Division of Gastroenterology, and Dr. Wasser.

Upcoming Seminars, Conferences and Meetings

Medical Grand Rounds

Medical Grand Rounds are held every Tuesday from noon to 1 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Topics to be discussed in May include:

May 6 - Neurology
May 13 - Physical Medicine & Rehabilitation
May 20 - General Internal Medicine
May 27 - Geriatrics

For more information, please contact Becky Sherman in the Department of Medicine at 402-8200.

Department of Pediatrics

In the Shadow of Illness: Parents and Siblings of the Chronically Ill Child will be presented by Myra Bluebond-Langner, PhD, Professor of Anthropology, Rutgers University, Camden, NJ, on Friday, May 9.

Pediatric MRI: Case Presentations will be presented by Elliot I. Shoemaker, MD, and Howard D. Rosenberg, MD, Department of Radiology/Diagnostic Medical Imaging, Lehigh Valley Hospital, on Friday, May 30. This presentation will be sponsored by Lehigh Magnetic Imaging Center (LMIC) who will also provide lunch for the program.

There will be no conference on May 23.

The above conferences will be held at noon in the hospital Auditorium at 17th & Chew. For more information, contact Kelli Ripperger in the Department of Pediatrics at 402-2540.

Psychiatric Grand Rounds

The Department of Psychiatry will host a presentation by Dr. George DuPaul of Lehigh University. Dr. DuPaul is a nationally recognized expert in the field of Attention Deficit Hyperactivity Disorder. The presentation will be part of the Grand Rounds Series and will be held on Thursday, May 15, from noon to 1 p.m., in the hospital's Auditorium at 17th & Chew.

For more information, contact Bruce Curry in the Department of Psychiatry at 402-2810.

Correction

The newly revised short form History and Physical for Ambulatory Surgery (MRD-60) is available for distribution through the hospital's Print Shop. It was incorrectly listed in last month's issue of Medical Staff Progress Notes as being available through the "Pick and Pack" system.

These forms may be ordered through e-mail. Select Bulletin Boards, /LVH Forms, then choose "Use" Photocopying Request. Please fill in the form completely. If you do not have e-mail, MRD-60 forms may be ordered by completing a photocopy request which is available through the Print Shop. For more information or to obtain photocopy request forms, please contact Grant Follweiler in the Print Shop at 402-8562.

Medical Staff Trivia

Of the 812 members of the Medical Staff, the name, John, is the most predominant first name with 44, followed by Robert as a close second with 41.

Call Park Instructions

A. Recommendations for Call Park Usage

1. Emergencies and/or priorities - Physician to physicians should be done for emergencies and/or priority calls.
2. Paging from a car phone or from a place where a call back is not possible.
3. Patient to Physician - Only when a call back is not possible.
4. Not to be used by Physician's or Employee's families.
5. Not to be used for personal reasons.

B. Call Park Prefixes

111 - STAT Call
222 - Call from a family member
333 - Call from a hospital employee
444 - Call from a patient
666 - Call from a physician
777 - Business call

C. Call Park Retrieval

1. Inside the Hospital
   a. Dial the last 4 digits of the call park number as indicated on the pager display. (The last 4 digits will always begin with 09.)
   b. Call is connected, begin the conversation.

   Example of a call park call from a physician:
   Pager display 666-402-0963
   Dial: 0963
   Begin conversation

2. Outside the Hospital
   a. Dial 402 plus the 4 digit call park number indicated on the pager display.
   b. You will hear a dial tone for approximately 3 seconds.
   c. When dial tone **stops**, wait for a connect with takes approximately 2 seconds.
   d. Call is connected. Begin conversation.

   Example of a call park call from a patient:
   Pager display 444-402-0963
   Dial: 402-0963
   Hear dial tone
   Hear silence for 2 seconds
   Connection made; begin conversation.

3. Busy Signal
   a. If you receive a fast busy signal, all circuits are busy. Hang up and dial the call park number again.
   b. If you receive a regular busy signal, the caller has hung up. Call the Page Operator (402-8999) for the caller's name and number.

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, status changes, etc. Please remember to update your directory and rolodexes with this information.

Medical Staff

Appointment

Mary P. Fabian, MD
Emaus Avenue Family Practice
(Domenic M. Falco, DO)
1101 W. Emaus Avenue
Allentown, PA 18103-5929
(610) 797-2000
FAX: (610) 791-5814
Department of Family Practice
Provisional Affiliate

Status Change

Jerome Dunn, MD
Department of Pediatrics
Division of Allergy
From Active to Honorary

Kenneth M. McDonald, MD
Department of Surgery
Division of Vascular Surgery
From Active to Two Year Leave of Absence

Address Change

P. Denis Kuehner, DO
Orefield Medical Center
5074 Kernsville Road
Orefield, PA 18069-2320

Peripheral Vascular Surgeons, PC
Victor J. Celani, MD
James J. Goodreau, MD
James L. McCullough, MD
Kenneth M. McDonald, MD
John F. Welkie, MD
1259 S. Cedar Crest Blvd.
Suite 301
Allentown, PA 18103-6206

Resignations

Ruben A. Gonzalez-Florin, MD
Department of Pediatrics
Division of General Pediatrics
(Allentown Pediatrics Association)

David J. Hetzel, MD
Department of Obstetrics and Gynecology
Division of Gynecology
Section of Gynecologic Oncology
(Lehigh Valley Women's Cancer Center - Gazi Abdulhay, MD)

Luis F. Oxholm, DO
Department of Psychiatry
(LVPG - Psychiatry)

Dean A. Ruble, DO
Department of Medicine
Division of General Internal Medicine
(Whitehall Medical Center)

Andrea C. Taroli, MD
Department of Pediatrics
Division of General Pediatrics
(Pediatric Clinic)

Allied Health Professionals

Appointments

Michele S. Gombert
Physician Extender
Technical
Clerical
(John J. Cassel, MD, PC - Dr. Cassel)

Michelle Julian, RN
Physician Extender
Professional
RN
(Cardiovascular Associates - Dr. Marcus)

Ramona M. McCormick, CRNA
Physician Extender
Professional
CRNA
(Allentown Anesthesia Associates - Dr. Maffeo)

Kelly I. Pessel, RN
Physician Extender
Professional
RN
(Cardiology Care Specialists - Dr. Rossi)

Pamela R. Stocker, RN
Physician Extender
Professional
RN
(Cardiology Care Specialists - Dr. Rossi)

(Continued on Page 12)

(Continued from Page 11)

Change of Supervising Physician

Sandra K. Stufflet, RN
Physician Extender
Professional
RN
From Dr. Candio at Candio, Feldman, Kovacs, Guillard & Lakata to Dr. Ordway at InterValley Cardiology

Resignations

June M. Danweber, RN
Physician Extender
Professional
RN
(Lehigh OB/GYN, PC - Dr. Lam)

Linda C. Fenstermaker, LPN
Physician Extender
Professional
LPN
(John J. Cassel, MD, PC - Dr. Cassel)

Guila Glosser, PhD
Associate Scientific
Psychologist

Barbara J. Koons, CRNP
Physician Extender
Professional
CRNP
(Center for Women's Medicine - Dr. Klasko)

Michele L. Lerch, RN
Physician Extender
Professional
RN
(InterValley Cardiology- Dr. Subzposh)

Suzanne L. Lindenmuth, CRNA
Physician Extender
Professional
CRNA
(Allentown Anesthesia Associates - Dr. Maffeo)

Jeffrey L. Mattson
Physician Extender
Technical
Surgical Technician
(Panebianco-Yip Heart Surgeons - Dr. Yeisley)

Betty L. McGinness, LPN
Physician Extender
Professional
LPN
(Lehigh Valley Pain Management - Dr. Khan)

Clarice A. Miller, CMA
Physician Extender
Technical
Medical Assistant
(ABC Pediatrics - Dr. Fugazzotto)

Karen A. Ruth
Physician Extender
Technical
Dental Assistant
(Marsha A. Gordon, DDS)

Diana M. Searfoss
Physician Extender
Technical
Surgical Technician
(Harry W. Buchanan IV, MD)

Marie H. Steciw, RN
Physician Extender
Professional
RN
(Lehigh Valley Ophthalmic Associates, PC - Dr. Listhaus)

Pamela L. Vandenberg, CRNP
Physician Extender
Professional
CRNP
(Michael D. Pasquale, MD)

Death

Sharon M. Wittman, RN
Physician Extender
Professional
RN
(ABC Pediatrics - Dr. Fugazzotto)

777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820
Tel: 717-558-7750
Fax: 717-558-7840
E-MAIL: STAT@PAMEDSOC.ORG

Pennsylvania
MEDICAL SOCIETY®

April 8, 1997

Robert X. Murphy Jr., MD, President
Lehigh Valley Hospital Medical Staff
P.O. Box 689
Allentown, PA 18105-1556

Dear Dr. Murphy:

Thank you for the kind message of appreciation expressed in your letter dated March 13, 1997. I have had the opportunity to speak to many groups in recent months. I can honestly say that nowhere did I receive a warmer welcome than at Lehigh Valley Hospital.

You were correct when you wrote that I "may be heartened to learn" that several members of your medical staff expressed interest in membership. As you know, physician support of organized medicine is the linchpin to our future success. Without unity, we will not succeed in forging positive changes in our health care system.

Would it be possible for you to forward the names of these physicians to either Lou Eister, Executive Director of the Lehigh County Medical Society (610-437-2288) or Judd Mellinger-Blouch, the Director of Marketing for the State Society (1-800-228-7823) and copy me? Lou or Judd can then follow-up with these physicians, supplying them with the information they need to become members.

Again, thank you for hosting me at Lehigh Valley Hospital and for your kind letter. Please let me know if there is any other way I can be of service. Keep up the good work, Bob.

Sincerely,

Victor F. Greco, MD
President

cld/p/lehighv

cc: Louis L. Eister
Judd A. Mellinger-Blouch

Surgeons face changes

Medicare fee adjustments will affect doc-hospital relations

By Jonathan Gardner

Looming changes in Medicare's practice-expense compensation formula for physicians could force hospitals to adjust financial arrangements with their medical staffs.

Facing losses of up to 44% in their Medicare income, some surgeons may want to close their private offices and sell their practices or ask for office space in the hospitals in which they operate.

Meanwhile, higher payments for specialty procedures performed in physicians' offices may motivate doctors to reduce the number of services they deliver in hospital outpatient departments or freestanding surgical centers.

"I think the incentives will be to take something into the office as much as possible, or if there's nothing to take into the office, reduce those costs by changing their practices," said Randy Fenninger, co-chairman of the Practice Expense Coalition, a group of specialty groups opposed to the change.

"It really perversely affects anybody who does a procedure outside of the office," said William Rich, M.D., secretary for federal affairs for the American Academy of Ophthalmology and a general ophthalmologist in Falls Church, Va.

The fight, previously a dispute between primary-care doctors and specialists, has finally spilled into the hospital sector.

Academic medical centers, which are intensive providers of specialty care, say the expected reductions in reimbursement for specialty services could dam the flow of dollars from their faculty practice plans to their teaching and research programs.

Faculty practice plan revenues represented 33% of medical school revenues in 1994-1995.

"The worry is that the surgical specialties will be far less amenable to cross-subsidization to nonsurgical primary-care activities," said Robert D'Antuono, assistant vice president in the division of healthcare affairs for the Association of American Medical Colleges.

The AAMC has joined many specialty groups in asking HCFA to delay implementation of the new compensation formula so it can be refined.

Practice-expense reimbursement represents about 41% of physicians' Medicare revenues, which are expected to reach $30.7 billion in federal fiscal 1997. In 1995, Medicare represented nearly one-fifth of all spending on physician services in the U.S., a share that is growing slowly.

In late January, HCFA released preliminary estimates on the effects of its change to so-called "resource-based" practice-expense reimbursement, which will convert physicians' overhead compensation to a formula resembling that of physicians' work compensation. Under a 1994 law, the change to resource-based compensation must take place on Jan. 1, 1998.

Practice-expense payments—which compensate physicians for the office staff, utility, rent and equipment costs attributable to serving Medicare beneficiaries—previously had been based on historical charges.

The new resource-based formula will cause steep drops in payments for some surgical specialties and small boosts for some primary-care specialties, according to HCFA's projections.

That will occur because HCFA reasons that hospitals and other institutions assume many of the practice costs of procedures delivered in those settings, while the physicians themselves bear most of the costs of office-based services.

As a result, HCFA plans to set higher practice-expense fees for routine services if they are delivered in an office than if they are delivered in hospitals or other out-of-office settings.

For instance, under one HCFA scenario, practice-expense compensation for skin lesion trimming or removal will be nearly twice as high in many cases if done in the physician office than if performed in a hospital.

That will give an incentive for those specialists who have a choice to divert more procedures into an office setting, even if, in some cases, it means purchasing expensive equipment.

"To determine whether I'm going to move a procedure from a nonoffice setting to an office setting, or vice versa, is going to depend on an analysis of where I'm better off," said Lawrence Goldberg, director of national healthcare affairs for Deloitte & Touche in Washington.

Those specialties dependent on invasive surgical procedures, however, won't be able to make such adjustments to their practices and face significant reductions in their practice-expense compensation. That loss of income could motivate them to reduce costs by closing offices and seeking space in hospitals, or to sell their practices to hospitals or health systems.

In a letter to HHS Secretary Donna Shalala, Paul Ebert, M.D., director of

Continued on p. 44

Winners and losers in Medicare physician fee shifts

HCFA has calculated which specialties can expect to see their Medicare income increase and which can expect decreases when it changes practice-expense reimbursement from a historical charge basis to a resource-based formula. That change is scheduled to occur Jan. 1, 1998.

Winners	Increase in Medicare revenues
Chiropractors	27-54%
Dermatologists	17-40%
Optometrists	35-40%
Podiatrists	23-41%

Losers	Decrease in Medicare revenues
Cardiac surgeons	32-44%
Neurosurgeons	25-30%
Thoracic surgeons	28-40%
Vascular surgeons	17-31%

Source: HCFA

Docs on cutting edge

Proposal seeks efficiency via reduced Medicare payments

By Jonathan Gardner

In trying to squeeze billions of dollars in savings from the Medicare program, President Clinton has dusted off a proposal to cut payments to physicians on "high-volume" hospital staffs.

The plan potentially could force some hospital executives to seek new ways to limit the volume of services their staff physicians provide.

Coupled with HCFA's plans to change how Medicare pays doctors for their practice expenses, the budget provision may test hospital-physician relationships even further.

The White House proposal is estimated to save about $2 billion between 1998 and 2002. It would target hospital staffs that deliver at least 25% more services per hospital admission than the national median. Rural hospital staffs could exceed the national median by 40% before they would be subject to the payment cuts.

Under the proposal, which has appeared in past White House balanced-budget plans, HCFA would withhold 15% of each Medicare payment to physicians on high-volume hospital staffs beginning in 2000. If the staff successfully collaborates to reduce its volume, the physicians would receive their payments, plus interest, at the end of the year. The goal is to increase physician efficiency.

The proposal is one of three physician payment reforms seeking a total of $7.4 billion in savings over five years.

The White House justifies it by citing studies that show even after accounting for severity of illness, teaching programs and the number of low-income beneficiaries they treat, utilization at some hospitals is unusually high.

Although the plan wouldn't affect direct Medicare hospital payments, it would force hospital executives to deal with some thorny management issues.

Those issues include managing the utilization of relatively unorganized hospital staffs; keeping physicians from diverting their patients from a hospital HCFA has labeled high volume to one it hasn't; and accounting for the high volume that occurs at hospitals with respected specialty programs, such as academic hospitals.

"It's unnecessary micromanagement, and there's no evidence to suggest that there is abuse," said Stephen Cooper, a lobbyist representing the Healthcare Association of New York State.

Unless hospitals directly employ a significant number of their staff physicians, some provider group representatives said, they may find it difficult to force doctors to cut back on how many services they provide to Medicare beneficiaries.

In particular, said James Bentley, senior vice president for policy development at the American Hospital Association, hospitals may face the argument from physicians that any effort to clamp down on utilization ignores how ill their patients are and how many services they need.

Yet hospitals also would feel compelled to try to placate physicians in order to keep them from sending patients to other facilities.

In forcing hospital executives to confront these issues, HCFA would be handing them responsibility for restraining the high volume of healthcare services their physicians provide, Bentley said.

"The hospital becomes the heavy hand," he said.

But some provider group representatives questioned how hospitals could achieve such a goal.

"You tell me how hospitals are going to organize those physicians," said Brent Miller, vice president of public policy and political affairs at the American Medical Group Association. "What's a hospital to do? Deny admissions?"

Specialists, meanwhile, worry they would be unfairly burdened by the plan, which they say doesn't account for the quality of care delivered in some top-flight programs. ❑

Surgeons *Continued from p. 42*

the American College of Surgeons, said the shift in practice-expense compensation could cause Medicare payments for heart transplants to drop by 57%, for coronary artery bypass operations by 44%, and for brain surgery and hip replacement by 40%.

That explains the big losses in Medicare revenues expected for such specialties as cardiac and thoracic surgery (See chart, p. 42). And those big losses explain surgeons' new push to delay the effective date of the new compensation formula so HCFA can rework it.

"There's no way that anybody can take elimination of a quarter of their reimbursement in one fell swoop," said Marie Michnich, senior associate executive vice president with the American College of Cardiology. "This takes $830 million out of cardiology beginning Jan. 1."


Doherty


Michnich

In addition, the specialists question HCFA's estimates of revenue implications because they varied widely on how much different specialties would gain or lose under resource-based compensation.

"We don't think this is refinable," said Rich of the ophthalmologists group.

In a letter to HCFA Administrator Bruce Vladeck, the American Medical Association weighed in.

The AMA repeated its call for a one-year delay in the implementation date so HCFA and specialty groups can work together to develop a formula that will not "adversely affect Medicare patients' access to quality healthcare services."

The primary-care specialties, however, argue that the current payment formula is unfair to them. They say the resource-based formula should take effect as planned next year on an interim basis that can be refined.

"It's much better to work toward implementation under the current time frame rather than throwing up our hands and saying the whole thing needs to be scrapped," said Robert Doherty, vice president for governmental affairs and public policy at the American Society of Internal Medicine. ❑

POLICY NO: AD 6850.00

SUBJECT: Adult Code Blue Procedures LVDI, MRI, Cancer Center, 1210,1230, 1240, 400 & 401

EFFECTIVE DATE: September, 1996

AREAS AFFECTED: All Departments

I. **POLICY**

A. A procedure shall be established to assure the hospital Code Blue Team and Emergency Medical Service respond to cardiopulmonary arrests in the Lehigh Valley Diagnostic Imaging (LVDI), Magnetic Resource Imaging Center (MRI) and Morgan Center (ground and first floor areas).

B. EMS only shall respond to cardiopulmonary situations in the 1210 (MOB I), 1230 (MOB II) 1240 (atrium and floors 2-4), 401 (Allentown Medical Center) and 400 (Fairgrounds Medical Center). ***Refer to Attachment A***

II. **SCOPE**

Hospital Code Blue Team personnel responding to cardiopulmonary arrest situations in LVDI, MRI and Morgan Center ground and first floor areas.

III. **DEFINITIONS**

ACLS - Advanced Cardiac Life Support.

AMC - Allentown Medical Center

CPR - Cardiopulmonary Resuscitation

EMS - Emergency Medical Service.

FMC - Fairgrounds Medical Center

Hospital Personnel - includes, but is not limited to, all employees, medical staff, allied health professional staff, students, volunteers, and others engaged in any activities at the hospital, excluding patients and visitors (JCAHO).

LVDI - Lehigh Valley Diagnostic Imaging

MC - Morgan Center

MRI - Magnetic Resonance Imaging.

IV. **PROCEDURE**

Action	Responsibility
A. Code Blue in LVDI, MRI and MC--ground and lobby levels	

Action		Responsibility
1.	Code Blue Procedure a. Perform CPR on victim as appropriate.	Affected Personnel
	b. Refer to the Code Blue Procedure, Adult CC & I-78, AD #6830.00 or EP#	Affected Personnel
2.	Notification of Code Blue Situations:	
	a. Dial 555 and notify of the following: Adult Code Blue, Location (LVDI, MRI, MC--floor, suite number or specific designated area)	Affected Personnel
	b. Dial 911 and notify of the following: Adult code blue Location Suite or designated area Advise of need for ACLS ambulance	Security Dept. Head
	c. Notify the following via pager simultaneously: Designated Medical Resident Anesthesia Nursing Supervisor/Triage Nurse Respiratory Care Designated Critical Care Nurse Pastoral Care	Security Dept. Head
	d. Announce via public address System, "Adult Code Blue, the building and specific location."	Security Dept. Head
B.	Code Blue Resources	
	Refer to Attachment B.	Affected Personnel
C.	Post Code Response Follow-Up	
1.	***Refer to Attachment C.***	Affected Personnel
2.	Provide a quarterly activity report to the following for review and approval: • Special Care Committee • Emergency Management Committee	Code Blue Committee Chair
3.	Review and approve summary report submitted as appropriate to assure Code Blue Response Procedure effectiveness.	Special Care Committee Chair Emergency Management Committee Chair

D. Response to MOB I (1210), MOB II (1230), Affected Personnel MC (1240--atrium, floors 2-4), AMC (401) and FMC (400)*Refer to Attachment A.*

V. ATTACHMENTS

Attachment A, "EMS Response Areas"
Attachment B, "Code Blue Resources"
Attachment C, "Post Code"

VI. DISTRIBUTION

Administrative Policy Manual
Emergency Preparedness Policy and Procedure Manual

VII. APPROVAL

Signature	President and CEO Title	12/19/96 Date
John Castaldo Signature	President, Medical Staff Title	12/20/96 Date

VIII. POLICY RESPONSIBILITY

Critical Care Director
Director, Environmental Health & Safety

IN COORDINATION WITH:

Code Blue Committee

IX. REFERENCES

JCAHO Accreditation Manual for Hospitals - 1993
Advanced Cardiac Life Support - 1993
Administrative Policy AD 6830.00 Code Blue Procedures-Adult-CC & I-78

X. REVISIONS

Hospital reserves the right unilaterally to revise, modify, review, rescind or alter the terms and conditions of this policy within the constraints of the law, by giving reasonable notice.

XI. OTHERS

N/A

XII. DATES

Origination: 1/84
Last Review: 9/96
Next Review: 4/98

Medical Executive Committee: _____
Management Committee: _____

c:\wp61\policy\6000\6350.00

EMS RESPONSE AREAS

Emergency Medical Services shall respond to cardiopulmonary situations in the 1210 (MOB I), 1230 (MOB II), 1240 (atrium and floors 2 through 4, Cancer Center), 401 (Allentown Medical Center) and 400 (Fairgrounds Medical Center).

The hospital Code Blue Team will not routinely respond to these designated areas.

Designated office personnel shall dial 911, stating unresponsive patient and need ACLS ambulance, building site, floor and office number.

CPR trained personnel shall begin CPR and continue until the ACLS Unit arrives.

ATTACHMENT B

CODE BLUE RESOURCES

LOCATION	CODE TYPE	UNIT PERSONNEL RESPONDING	EQUIPMENT
LVDI, MRI	ADULT	STU 1st Call MICU/SICU 2nd Call + Emergency Medical Services	Code Cart in unit + Portable equipment from ambulance
MORGAN CENTER, GROUND & LOBBY LEVELS	ADULT	STU 1st Call MICU/SICU 2nd Call + Emergency Medical Services	MC Multi-purpose area personnel bringing cart + Portable equipment from ambulance

POST-CODE

PERFORM	REASON	RESPONSIBILITY
Complete NSG-199, Rev. 2/94 Cardiopulmonary Resuscitation Record and forward to Critical Care Office, JDMCC, Suite #405.	Refer to AD#6830.00, Page 4, Section IV, Paragraph G, #7, 17, 18 & 19.	Affected Caregiver
Complete ADM-03, Rev 3/94, LVH Incident Report	When concerns are identified regarding: • equipment • personnel • recovery • notification	Affected Caregiver
Forward Completed Form ADM-03, Rev 3/94 to Department of Environmental Health & Safety, 1243SCC, Suite 3122	Concerns are reviewed and addressed appropriately	Affected Caregiver
Review completed NSG-199, Rev 2/94 and coordinate follow-up action as required	Clinical procedures done appropriately	Code Blue Second Review Sub-Committee
Place Code Blue Response Procedure Follow-up on Code Blue Committee Agenda for review.		Critical Care Office Department Head

:geb

I. POLICY

This policy shall define the medical back-up policy for OB/GYN services at the 17th Street campus. Medical consultations will be readily available for these patients.

II. SCOPE

This policy shall apply to all hospital employees, medical staff and students.

III. PROCEDURES

Procedures for the medical back-up of the following patient types:

1. Medically stable patients requiring consultation -

    a. Physicians in the relevant speciality will be called by the attending physician at 17th Street, a resident or other staff. All consultations must be performed within 24 hours of request (or sooner if desired by the attending physician). It is the expectation of participating in the on-call rotations for specialty services that all physicians taking such call will be available to promptly meet the service needs of the 17th Street campus.

2. Patients in cardiopulmonary arrest -

    a. Patients who experience either a cardiac and/or a respiratory arrest will be managed according to the principles and procedures outlined in the existing code blue policy for the 17th Street campus.

3. Newly admitted patients being transferred to the 17th Street via ambulance -

    a. All admissions to the inpatient units at 17th Street who are admitted via ambulance will have their clinical status screened by emergency department personnel at 17th Street prior to being transferred to the patient

care area. Patients with unstable vital signs will be detained and further assessed while in the emergency department. The patient's attending physician will be promptly notified of the patient's whereabouts and medical condition. The emergency medicine attending in conjunction with the attending of record at the 17th Street facility will jointly decide upon the further appropriate disposition of the patient.

4. Medically unstable inpatients -

   a. If an inpatient becomes medically unstable, a "code purple" will be called by the attending physician, the resident or other involved health professional at the 17th Street location. The criteria for "medically unstable" will be considered as a significant alteration in vital signs requiring prompt intervention for stabilization, but not meeting the criteria for code blue status (i.e., no cardiac or pulmonary arrest). The determination of "medically unstable" will be made at the discretion of the attending physician, resident or health professional at 17th Street on the basis of the "need for prompt medical assistance".

   b. To initiate a "code purple" situation, a member of 17th Street professional team will call the hospital operator "1199" and request a code purple be called.

   c. The hospital operator upon receiving code purple notification will notify the following individuals of code purple status:

      1. The General Medicine/Ward Medicine Attending on-call (Monday - Friday, 0700 - 1700 hours)
      2. The medical resident on-call for 17th Street (week nights after 5:00 pm - 8:00 am the following morning and all day Saturday and Sunday)
      3. The attending anesthesiologist on-call for 17th Street
      4. The respiratory therapist on-call for 17th Street
      5. The triage nurse at Cedar Crest site who will contact the ICU nurse available on MICU/SICU at Cedar Crest site and the appropriate nursing supervisor on call for 17th Street site.
      6. The intensive care unit medicine attending on-call
      7. The emergency department attending at 17th Street

   d. Upon receiving the code purple notification the following individuals will directly report to the site of the code purple: attending anesthesiologists, respiratory therapists, chief OB/GYN resident, nursing supervisors,

MICU/SICU nurse. The general medicine attending will call the floor to establish familiarity with the situation and proceed directly to the floor to personally evaluate the situation (0700 - 1700, Monday - Friday). The medical resident on-call will promptly go the floor when in-house (week nights after 1700 - 0800, etc). The medicine intensive care unit attending will call the floor and establish familiarity with the case and give advice to the on-site physicians concerning immediate medical management.

e. Overall responsibility for the management of the patient lies first with the attending physician of record at the 17th Street site. If the attending physician is uncomfortable with this role, the attending anesthesiologist will assume responsibility for support of the patient's vital signs pending the arrival of the Ward Medicine Attending or medical resident on call. The General Medicine Ward Attending or medical resident on call will assume overall responsibility for the patient upon arrival. Further disposition of the patient will be at the discretion of the General Medicine Attending or medical resident on call and consultation with the Attending of record at 17th Street and the Intensive Care Unit Attending.

f. Patients who require further stabilization may be transferred to the emergency medicine department at 17th Street prior to ultimate transfer to the Cedar Crest campus.

g. In the event of the lack of a timely response from the general medicine attending or medical resident on call , medically unstable patients may be transferred to the emergency medicine department for further evaluation stabilization an disposition.

IV. DISTRIBUTION

Administrative Policy Manual

V. APPROVAL

Signature	Title	Date
	President & CEO	2/2/97
	President, Medical Staff	
	Sr. VP Clinical Services	2/25/97

VII. POLICY RESPONSIBILITY: **IN COORDINATION WITH:**

Chief of Obstetrics — Sr. VP of Clinical Services

IX. REFERENCES

N/A

X. REVISION

Hospital reserves the right unilaterally to revise, modify, review, rescind or alter the terms and conditions of this policy within the constraints of the law, by giving reasonable notice.

XI. OTHERS

N/A

XII. DATES

Origination: January, 1997
Last Review: January, 1997
Next Review: October, 1999

c:\wp61\policy\6000\purple.pol

HEALTH NETWORK LABORATORIES

A Service of LEHIGH VALLEY HOSPITAL

Approval of New Chemistry Profiles

New laboratory panels were approved by the American Medical Association (AMA) and accepted by the HealthCare Financing Administration (HCFA). New billing codes will be mandatory by January 1, 1998. Health Network Laboratories has decided to institute these new panels effective in early May. A few days before the go-live date, Health Network Laboratories will send everyone an e-mail alert to that effect.

A small survey of the medical staff resulted in one continuing concern with our current panels -- **ADD A BUN TO THE CHEM 6!!** We had decided to institute this addition and fortunately the government agrees. They defined a **Basic Metabolic Panel** to be electrolytes, BUN, creatinine, and glucose. This profile will now be referred to as a **Basic Metabolic Panel** and should, therefore, be ordered as such.

In addition, they allow an Electrolyte Panel (the traditional 4 ions) and a new **Hepatic Function Panel A** which includes Albumin, Total and Direct bilirubin, alkaline phosphatase, AST and ALT (6 tests). This profile will be available to be ordered as a **Hepatic Function Panel A**.

A **Comprehensive Metabolic Panel** is new and almost identical to our inpatient profile. To be consistent, we will adopt the name **Comprehensive Metabolic Panel** and it will contain the following changes: replace ALT with AST, replace GGTP with alkaline phosphatase, and drop uric acid. As new changes occur with HCFA, we will keep you informed.

Please remember that individual test orders are still highly recommended and are more easily medically justified than panels. Additionally, all tests ordered on Medicare must be medically necessary. Should profiles or panels contain medically unnecessary tests for the management of a specific patient, they should not be used. Rather, individual tests, each medically necessary, should be ordered.

If you have any questions regarding these profiles, please contact Gerald E. Clement, PhD, Technical Director, Clinical Laboratories, at 402-5589.

Laboratory Test Ordering

Health Network Laboratories strives to provide the best quality service. When you order a test, we want to do the correct test and report the results in a timely manner. However, sometimes the test order script is unclear and uninterpretable. We try to clarify the test through a number of procedures including calling the ordering physician. This delays obtaining the correct specimen with inconveniences to both the patient and the physician. Secondly, if we interpret the test request incorrectly, the physician does not receive the expected results, and the laboratory is not reimbursed for the test.

Please give your patients clear test request scripts. If you have any ideas that the laboratory can institute to help solve this problem, please contact Health Network Laboratories at 402-8150.

In order to give you an idea of the unclear scripts that are received, each month we will publish a "Script of the Month."

Following is this month's "Script of the Month" which was received in the outpatient laboratories:

DRAW BLOOD AND SEND TO
REFERENCE LABORATORY

If you have any questions regarding this issue, please contact Gerald E. Clement, PhD, Technical Director, Clinical Laboratories, at 402-5589, or John J. Shane, MD, Chairperson, Department of Pathology, at 402-8152.

THERAPEUTICS AT A GLANCE

The following actions were taken at the March - April -1997 Therapeutics Committee Meeting Maria Bar, Pharm.D., BCPS, Barbara Leri, Pharm.D., Howard Cook, R.Ph, BCNSP, FASHP

rPA NOT SUPERIOR TO tPA

Reteplase (rPA, Retavase, Boehringer Mannheim) is a new tissue plasminogen activator thrombolytic agent recently marketed for the treatment of acute myocardial infarction as a rival to tPA. rPA is administered as double bolus of 10 units each given 30 minutes apart. Early studies (Rapid I and Rapid II) showed higher rates of early reperfusion with rPA compared to accelerated or "front-loaded" tPA without an increase risk of complications.

Results from GUSTO 3, a recent mega-trial of > 15,000 patients were recently presented at the American College of Cardiology Annual meeting. Patients were randomized to receive rPA or tPA with 30 day mortality as the primary endpoint. After 30 days, 7.4% of patients given rPA died, compared to 7.2% on tPA. Statistically, no difference between the two agents was found.

The Therapeutics Cardiology Subcommittee reviewed the available data as summarized below:

- Clinical trials to date fail to show superiority of rPA
- LVH's experiences to date with tPA
- No risk-vs-benefit advantage to add rPA to formulary

The subcommittee recommended not to add rPA to the LVH formulary with the consensus agreement of the Therapeutics Committee.

CURRENT RECOMMENDATIONS FOR VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS AT LVH

On March 19, 1997, a subcommittee of the Therapeutics Committee met to discuss the current recommendations for VTE prophylaxis. The subcommittee was comprised of representatives from orthopedics, trauma, hematology/oncology, OB/GYN, pulmonary, internal medicine, pharmacy and finance. The current literature was reviewed regarding low molecular weight heparin, unfractionated heparin and warfarin utilized by the various disciplines. The following are the recommendations of the subcommittee for VTE prophylaxis:

Orthopedic (hip and knee replacement):	warfarin
General Surgery:	unfractionated heparin plus sequential compression devices (SCD)
Trauma Surgery:	warfarin and/or low molecular weight heparin (only for high risk patients defined by VTE protocol) until able to take warfarin and SCD
Hematology/Oncology:	warfarin
OB/GYN:	unfractionated heparin
Other Uses	
Interventional Cardiology:	unfractionated heparin and current thrombotic regimens (Poor literature support for use of LMWH post intervention).

Presently, low molecular weight heparin is on the LVH formulary restricted to the high-risk trauma patients **only.** It was the decision of the subcommittee to maintain the current status of LMWH. The only exception would pertain to patients who would normally receive warfarin who are unable or very difficult to be phlebotomized in order to monitor INR's for warfarin adjustment. For these rare patients, it must be clearly written on the physicians order, that the patient is unable to receive warfarin due to difficulty in blood draws. This explanation must accompany the order for the formulary low molecular weight, enoxaparin (Lovenox) 30mg SQ Q12H to be dispensed.

The subcommittee felt additional, more persuasive literature was required prior to changing the current practice for VTE prophylaxis at LVH.

The above information was discussed solely with regard to prophylaxis rather than treatment of VTE. Please note, the selection, doses and duration of therapy are significantly different in this setting compared to prophylaxis.

This topic will be continually reviewed and revised by the subcommittee as more data becomes available.

IV VERAPAMIL STILL FIRST-LINE AT LVH

The Cardiology Subcommittee revisited the IV diltiazem (Cardizem^{R}) usage criteria initially developed in 1992. The subcommittee members were an agreement with the criteria as stated below:

Criteria for Use:
IV Diltiazem intermittent boluses and/or continuous infusion can be administered after meeting one of the following criteria:

1. Failure of I.V. verapamil.
   Failure defined as inadequate HR control after a total cumulative IVP verapamil dose of 20mg followed by a continuous infusion of verapamil 10mg/hr x 1 hour.
2. And/or Intolerance to a 5mg I.V. verapamil dose defined as:
   a. A decrease in systolic blood pressure of 10mmHg from baseline or < 90mmHg and symptomatic.

      OR

   b. New onset or worsening CHF signs and symptoms.

      OR

   c. Documented allergy to verapamil HCL
3. Baseline symptomatic hypotension < 90mmHg requiring pressor agents or, EF $\leq$ 35% and/or PCWP $\geq$ 20mmHg.

**I.V. Diltiazem will not be used as a p.o. substitute in NPO patients.

There is an under utilization of IV verapamil infusions at LVH. Prescribers are encouraged to consider verapamil infusions rather than intermittent IV bolus for patients requiring heart rate control. The use of a constant infusion of verapamil may avoid the hypotension and wide range of ventricular heart rate responses frequently seen with repeated bolus doses.

Several studies supporting the safety and efficacy of verapamil by continuous infusion have been published. The usual dosing regimen starts with a 5-10mg IV bolus over at least 2 minutes followed by initiating a continuous infusion oft 5mg/hour. Dose titration to control ventricular rate below 100 beats/minute should be done every 15-30 minutes at 2.5-5mg increments. There are no published guidelines regarding the maximum recommended rate and duration of infusion. Based on several case reports, the use of a continuous verapamil infusion appears to be safe when administered up to a rate of 15mg/hour for a duration of 7 days. One case report published described the use of a verapamil infusion for 33 days without an adverse effect suggesting that durations longer than one week can be safely employed.

REZULIN ARRIVES FOR MANAGEMENT OF TYPE II DIABETES - AMARYL DEPARTS

Troglitazone (Rezulin[R] - Parke-Davis), a thiazolidinedione oral antihyperglycemic agent which acts by improving target cell response to insulin, has been approved for formulary inclusion at LVH. It improves sensitivity to insulin in muscle and adipose tissue and inhibits hepatic gluceneogeneiss. Troglitazone is not chemically or functionally related to the sulfonylureas, the biguanides or the alpha-glycosidase inhibitors.

The mechanism of action of troglitazone is thought to involve binding to nuclear receptor (PPAR) that regulate the transcription of a number of insulin response genes critical for control of glucose and fat metabolism. It does not depend on insulin for its effect. It is currently approved by the FDA for use in patients with type II diabetes currently on insulin therapy whose hyperglycemia is inadequately controlled (HbA_{1c} > 8.5%) despite insulin therapy of over 30 units per day given as multiple injections. A supplemental NDA for troglitazone as monotherapy and for combination use with sulfonylureas was submitted by the manufacturer in early February.

Troglitazone therapy should be initiated at 200mg once daily, with a meal, in patients on insulin therapy. The current insulin dose should be continued upon initiation of therapy. For patients not responding adequately, the dose of troglitazone should be increased often approximately 2-4 weeks. The usual dose of troglitazone is 400mg once daily, with a maximum recommended daily dose of 600mg. It is recommended that the insulin dose be decreased by 10-25% when fasting plasma glucose concentrations decrease to less than 120mg/dL in patients receiving concomitant insulin and troglitazone. No dosage adjustment in patients with renal impairment is required - this may provide an advantage to those patients that are not appropriate candidates for Meftormin (Glucophage[R]). Troglitazone should be used with caution in patients with hepatic disease.

Clinically significant drug interactions include: Concomitant administration of cholestyramine which reduces absorption of troglitazone by 70%. Troglitazone may decrease the effectiveness of combinations of ethinyl estradiol and norethindrone contraceptive therapies. Troglitazone may induce drug metabolism by CYP3A4 and this action should be taken into consideration when prescribing other agents which use this metabolic pathway (i.e. cyclosporine, tacrolimus).

Adverse effects observed include headache, infection, pain, dizziness, asthenia and nausea. Two patients in the clinical studies developed reversible jaundice which was consistent with idiosyncratic drug reaction on liver biopsy.

Troglitazone is available as 200mg and 400mg non-scored, film coated tablets. The 200mg tablets cost $2.84 each; the 400mg tablets, $4.36 each.

Glimipiride (Amaryl[R]), an oral hypoglycemic agent approved for formulary in October 1996 as possessing advantages to existing sulfonylureas, was removed from formulary status due to minimal usage and unrealized advantage over existing formulary agents.

COMING SOON... A NEW ANTINEOPLASTIC ORDER SHEET

A long awaited preprinted order sheet addressing chemotherapy, fluid replacement and pre and post antiemetic therapies has been devised. The order sheet will comprehensively include details regarding the patient's necessary demographics laboratory vascular access and investigational protocol information.

Through standardization of the order sheet, more consistent information can be relayed to all health care providers and possible medication errors can be avoided. Following, a short 1 month pilot evaluating the present antiemetic regimens use for different therapies, the order sheet will be distributed and utilized in the appropriate areas.

PHYSICIAN ORDER SHEET CHANGE

In December 1996 at the Therapeutics Committee, the comment at the bottom of the physician order sheet was reviewed. The comment originally read "Authorization is hereby given to dispense the generic or chemical equivalent unless specifically underlined by the physician." This comment led to some confusion in dispensing, since many physician's may underline orders out of habit, rather than a requirement for the brand name product to be dispensed. In order to correct the misinterpretation of the statement the committee discussed alternatives and unanimously approved to change the statement to "Authorization is hereby given to dispense the generic or chemical equivalent unless specified as brand necessary by the physician." This statement was approved by the Therapeutics Committee and the information communicated to the Medical Executive Committee, via the Therapeutics Committee Minutes and appeared in the Physician's Progress News Letter.

New physician order forms printed from this point on, will have this new statement on the bottom. Older forms which have already been printed and may take 1-2 years until review and reprinting, will remain in circulation, though the original statement will not be considered valid. The necessity to write "Brand Necessary" will be instituted starting July 1, 1997 after you have had the opportunity to communicate the information, with your respective staff.

If you have any questions or concerns, please contact Fred Pane at Ext. 8882.

LEHIGH VALLEY
HOSPITAL

Issues in Medical Ethics

SPRING 1997

Physician-Assisted Suicide

Editorial

Principles, premise, practice and prediction. Underlying the topic of physician-assisted suicide lie assumptions and unwritten subtexts which need to be exposed to the light of day. By hiding behind **principles,** those standing against physician-assisted suicide make a firm boundary where greyness and uncertainty may really lie. Dr. Schick exposes the logic (or illogic) behind such a stance, taking a firm stand for providing a medical means of death.

Dr. Lizza takes issue with the **premise** behind physician-assisted suicide. Procedural safeguards of any kind, he argues, will not prevent abuse of the legalization of physician assisted suicide. The principle may be legitimate, but the premise is flawed.

The Krank decided to get a word in here too. Alluding to two who have **practiced** physician-assisted suicide, we are reminded of the difference between the kindly internist and the VW bus deathmeister. Those who practice physician-assisted suicide have forced us all to frankly assess the situation, none more brutally or candidly in practice than Kervorkian.

Principles, premise, practice and **prediction.** Yet I will take the editorial liberty of predicting that physician-assisted suicide, if put into legislation, will not utterly change the principles of medicine. Physicians will individually decide where they stand on the issues. Egregious errors in the premise will be exposed in the media rapidly, glaringly and garishly. Dangerous trends in practice will be halted by the outrage of society and the probity of the profession. My prediction is that changes in such laws are unlikely (since we really do not like change), will not play out as predicted by their sponsors, and will be repealed rapidly if they fail.

Why, after all, are we debating physician-assisted suicide? What would lead someone to seek the end of life in such an unnatural way? Fear of suffering, fear of loneliness, overwhelming sadness, debt, pain, the burden of age, a passing whim; different reasons can be constructed and conceptualized. What we need as a tonic to physician-assisted suicide is a conversation on the reasons why we are considering such a death. Where have we failed as society and as a profession in succoring suffering, lessening loneliness, and in general easing the sadness of death? How can

IN THIS ISSUE

we, at the end of life, maintain the value of life to the end? Let's have a conversation about why we are discussing physician-assisted suicide, to understand the principles, premise and practice which we are about to undertake.

Physician-Assisted Suicide from a Logical Point of View

Theodore Shick Jr.
Professor of Biomedical Ethics
Muhlenberg College

The question of physician-assisted suicide is not about whether it should be done, but about how it should be done. For there is widespread agreement that certain forms of physician-assisted suicide are morally permissible. When a physician removes a feeding tube from a patient in accord with an advance directive, for example, he or she is assisting a suicide. The United States Supreme Court has deemed such actions legal, and the Council on Ethical and Judicial Affairs of the American Medical Association has declared them ethical.

Removing patients from life-support apparatus is not the only way physicians assist suicide. According to Elizabeth Markson, Associate Director of the Boston Gerontology Center, "estimates suggest that as many as 70% of all deaths in hospitals [4200 of the 6000 per day] are preceded by *ad hoc, often sub rosa*, decisions to withdraw care[1]. "This form of assistance may not be as direct as removing a feeding tube, but it is assistance nonetheless."

Passive euthanasia—withholding or withdrawing medical care to put someone out of their misery—is generally considered morally permissible because it is not viewed as an act of killing. The physician doesn't directly bring about the patient's death; he or she simply lets the patient die. *Active* euthanasia—performing a lethal operation to put someone out of their misery—is morally problematic because it is unquestionably an act of killing. Not all killing is immoral, however. Killing in self-defense, for example, is not immoral. Is killing someone to end their misery immoral? There are good reasons for thinking that it is not.

Some things are intrinsically evil, such as intense suffering. And some things are inherently wrong, such as causing or allowing people to suffer intensely for no good reason. This insight can be stated in the form of a principle: unnecessary suffering is wrong. This principle can be used to formulate the following argument for active euthanasia:

1) Unnecessary suffering is wrong.
2) Allowing passive but not active euthanasia promotes unnecessary suffering.
3) Therefore, allowing passive but not active euthanasia is wrong.

[1] Elizabeth W. Markson, "Moral Dilemmas," *Society*, July/August 1992, p.4.

How does allowing passive but not active euthanasia promote unnecessary suffering? Consider the case of someone who is about to have their feeding tube removed. The decision has been made to end their life. Instead of ending it as quickly and painlessly as possible, however, current practice demands that they be starved to death. Even if they are comatose or drugged and thus don't experience the pain of starvation, their friends and loved ones must endure the pain of watching them waste away. Is this really necessary? Wouldn't it be more humane, more moral—to give such patients a lethal injection?

One can reasonably oppose active euthanasia only if one has a good reason for rejecting the foregoing argument. Since the conclusion follows from the premises, the only reason one can have for rejecting it is that one or more of it's premises is false. Premise 1 is generally considered to be self-evident or true by definition. In either case, the chance of finding a counterexample to it is not good. So those who object to this argument must reject premise 2. Specifically, they must show that the suffering brought about by not permitting active euthanasia is necessary. Some claim that it is necessary to prevent the medical profession from getting a bad name. If physicians trade the white coat of the healer for the black hood of the executioner, it has been argued, their image will suffer. But it's unclear that their image will suffer, and even if it will, it's unclear that the suffering produced will outweigh the suffering experienced by untreatable patients.

It's doubtful that physicians who perform active euthanasia will be looked upon as executioners. It's more likely that they will be looked upon as angels of mercy. Trading the white coat of the healer for the white wings of an angel may not be such a bad trade. Moreover, it can be argued that allowing active euthanasia will actually improve the image of the physician. For at present, many people fear being hospitalized for a terminal illness on the grounds that physicians will not take their pain seriously and will force them into "a childlike state of helplessness, diapered, sedated, incompetent."[2]

Then there is the slippery slope argument which says that if we allow physicians to put people out of their misery by killing them, the next thing you know they'll be killing everyone they don't like. (After all, look what happened to the Nazis.) Although I've heard physicians take this line, it seems to represent an unreasonably dim view of the medical profession. Moreover, I know of no scientific evidence to support the cause-effect relationship assumed by the slippery slope argument. The Nazi analogy is far too weak to have any probative value. In any event, a properly constructed law could keep such potential abuses to a minimum.

[2] 9th Circuit Court Judge Stephen Reinhardt, in *Washington v. Glucksberg*, 96 C.D. O. S. 1507.

Legalizing physician-assisted suicide, however, does not require legalizing active euthanasia. For there is a compromise position that secures most of the benefits of active euthanasia while avoiding most of its burdens: allow physicians to prescribe a means of committing suicide (such as barbiturates) to competent patients who are incurably ill and suffering intolerably. Safeguards, such as second opinions, committee approval, etc., could insure that the prognosis is correct and that the patient's suffering is not due to inadequate comfort care. Since patients themselves would administer the drug, physicians would not be cast in the role of executioner, and the incline on any slippery slope would not be very steep. It is not a totally ideal solution because it does not provide a way of ending the suffering of those who are paralyzed or unable to swallow. But it would alleviate much more unnecessary suffering than is now legally possible.

Legalizing Assisted-Suicide: Problems with Premise

John P. Lizza, Ph.D.
Assistant Professor of Philosophy
Kutztown University

Physician-assisted death may not always be a bad idea, but its legalization is. While there may be some "best-case" scenarios in which a physician assisting in the death of a patient would be good, its practice on a large scale, even with the procedural safeguards that have been proposed, would likely result in many unnecessary, undesirable, and involuntary deaths. This cost is not outweighed by the benefits that might be derived in some particular cases[1]. The likelihood of these deaths is apparent as soon as one begins to think of how radically indefinite and unrealistic the procedural safeguards are.

First, eligible patients would have to be "terminally ill." However, there is no generally accepted definition of terminal illness, and it is difficult, if not impossible, to predict accurately life expectancy. Although some states in their "natural death laws" have linked "terminal illness" to a life-expectancy of less than six months, such a prediction on the part of physicians will be a guess, at best, in many cases. Eligibility will thus rest on the subjective determination of individual physicians, and it is unrealistic to assume that physicians will get it right all or most of the time. It is also unlikely that physicians will be able to exclude

[1] See, for example, the "Oregon Death with Dignity Act," reprinted in Hastings Center Report 25:3 (1995), p.39.
[2] Ibid.

consistently their own subjective evaluation of the patient's quality of life from their estimates of whether patients are "terminally ill" for purposes of assisting in their death. Thus, it is likely that some people will die unnecessarily or because of someone's else idea of what kind of life is acceptable.

Second, the safeguards are supposed to ensure that the patient requesting assistance in dying understands the diagnosis and prognosis, is informed of all options, including pain control and comfort care, and is capable of making health care decisions and acting voluntarily. But this is unrealistic. Perhaps, in some cases, in which very knowledgeable physicians have a lot of time to devote to an individual patient, these safeguards could be met. However, in many other cases, they would not be met. How often in a clinical situation are patients informed of all options? Most physicians do not know all options, especially when it comes to palliative care. Must the patient's informed consent for assistance in dying be any more informed than the consent that is obtained for surgery or some other medical procedure? Presumably not. Either informed consent is obtained or it is not. However, anyone with any clinical experience knows that in actual practice how seriously the standard of "informed consent" is met varies from "the patient signed on the dotted line" to "the patient was truly informed." Confirmation by a consultant and repetition of the "consent" is no guarantee. The patient may have just signed on many dotted lines. The problem is that there are no additional safeguards to ensure that a higher standard of informed consent would be met. Instead, it is likely that, just as in other clinical situations, how well patients meet the standard would vary. The result, of course, is that there will be involuntary deaths, and that puts us smack in the realm of homicide.

Third, physician-assisted death would supposedly be restricted to patients who voluntarily request it. However, it would soon be followed by strong pressures to legalize aid in dying of incompetent patients who are unable to express their wishes. Just as we allow surrogates to decide to forgo treatment on behalf of incompetent patients, why continue to force life on patients just because they have now lost the capacity to ask physicians for aid in dying.

The danger, of course, is that many incompetent people, who are often demented and unable to assert their own interests, will be vulnerable to unwanted death. While some states have enacted strong requirements of proof about the wishes and interests of incompetent patients before allowing surrogates to forego life-sustaining treatment on their behalf, these requirements are, in fact, relaxed in day-to-day decisions about incompetents. In the vast majority of cases, there is no judicial oversight. Occasionally, ethics committees get involved, but the requirements of evidence and proof of the incompetent's wishes are much less rigorous

than in a court of law. Concerns such as the cost of medical resources and the emotional and financial interests of families may enter into the decision and erode the requirement of proof about what patients would want. Moreover, these concerns have probably played a disproportionate role in decisions involving patients without strong family and financial support. It is not that these concerns are illegitimate. ndeed, they are ethically relevant. However, they are being introduced surreptitiously and without the kind of scrutiny necessary to ensure that abuse has not occurred.

Thus, while there may be no inherent moral distinction between active and passive euthanasia, there are good, practical, moral grounds for drawing a legal line at this point, viz., the prevention of further abuse. It would be naive to think that a surrogate's interests or idea of an acceptable quality of life, rather than those of a patient, have never determined the decision to forego treatment. Thus, we may have already given too much authority to families and other surrogates to forego life-sustaining treatment for incompetents. Before we extend this power to include requests on behalf of incompetents for physician-assisted death, it would be better to ensure that surrogates are meeting the appropriate principles and procedural safeguards for decision-making in withdrawal and withholding care from incompetents.

Fourth, laws should not discriminate or unfairly impact on vulnerable segments of society. However, no controls are proposed as to how to ensure that this will not happen if physician-assisted death is legalized. Given how heath care resources are currently distributed in this country, legalizing physician-assisted death will unfairly affect those who are socially and economically disadvantaged. Just as costs adversely and disproportionately affect the quantity and quality of medical treatment that these people receive, it will adversely affect the kind of assistance in dying that they receive. For these people, who lack power and financial resources, it is even more likely that the procedural safeguards will not be consistently met.

Finally, some might object that if we followed this line of reasoning, it would prevent us from enacting any law, since it is impossible to ensure that any law receives one-hundred percent compliance. However, since abuse of laws governing physician-assisted death would constitute homicide, the state has a stronger obligation to ensure that these laws, as opposed to most other laws, would not be abused. We would need at least as stringent due process safeguards as those we currently have in place for capital cases. The problem is that no such safeguards have been proposed for physician-assisted death. Moreover, the state cannot give us this guarantee. The private nature and context in which these decisions would be made would prevent the oversight needed to meet the more stringent requirement of precluding abuse.

My Friend Jack: From the Pen of The Krank

Carlos Gomez, M.D., a well-known opponent of physician-assisted suicide recently said in an interview that he prefers Jack Kevorkian, M.D., to Timothy Quill, M.D., on the question of physician-assisted suicide. Gomez did not elaborate on why he came to this conclusion. Permit me to offer an independent confirmation of Gomez's judgment, with some reflections on what is at stake.

Timothy Quill appears to all persons as a reasonable and caring physician. He makes an effort to know his patients and to understand what they need. He wants physician-assisted suicide only for patients who are competent and who have come to the considered judgment that they need to have the control in their hands on how they die. Thus Quill says that we should legalize the possibility of physician-assisted suicide. As he describes it, it would happen only in those cases where the physician knew the patient and had exhausted other methods of caring for the dying. In short, Timothy Quill puts a kindly face on physician-assisted suicide.

Jack Kevorkian is different. His relationships with his "patients" are quite casual.He does not know them for an extended period of time. Indeed, there may be only one interview before Kevorkian assists them to their death. Unlike Quill, he does not seek an independent confirmation of their terminal diagnosis nor is there any persuasive evidence that he looks for evidence of treatable depression. According to some observers, he is so careless that he does not pick up on clues that would lead a reasonable observer to believe that the patient was being pressured into requesting assistance in suicide. In short, Jack Kevorkian is the antithesis of Quill. Why do I prefer him?

The preference for Kevorkian is a preference for candor in public policy discussion. Jack Kevorkian presents us with how physician-assisted suicide is likely to be practiced in this country, should it become legal. Practitioners will specialize in what Jack Kevorkian calls "medicine." It will not be limited in the ways in which proponents of physician-assisted suicide presume that it can be. Patients desperate and depressed will seek the "help" of these physicians. Note that even under the current legal situation, Jack Kevorkian still practices his art. Imagine the freedom he and physicians like him would enjoy under a different legal regime.

The "blessing" of Jack Kevorkian is that he makes this abundantly clear. For that we should be thankful. Perhaps we might also be concerned.

LEHIGH VALLEY
HOSPITAL

Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556

Medical Staff
Progress Notes

Robert X. Murphy, Jr., M.D.
President, Medical Staff
David M. Caccese, M.D.
President-elect, Medical Staff
John E. Castaldo, M.D.
Past President, Medical Staff
John W. Hart
Vice President
Rita M. Mest
Medical Staff Coordinator

Janet M. Seifert
Physician Relations
Managing Editor

Medical Staff Progress Notes **is published monthly to inform the Lehigh Valley Hospital Medical Staff and employees of important issues concerning the Medical Staff. Articles should be submitted to Janet M. Seifert, Physician Relations, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556, by the 15th of each month. If you have any questions about the newsletter, please call Mrs. Seifert at 402-8590.**
Lehigh Valley Hospital is an equal opportunity employer.
M/F/H/V